Fatema S. Uddin, MD, PLLC

HEALTH HISTORY FORM

Name _____ DOB _____ Date_____

Do you have any drug Allergies: Yes No
If Yes, please list the specific drug and your reaction to that medication:
Drug: _____ Reaction: _____
Drug: _____ Reaction: _____

Medical Problems
Please list every medical problem for which you are being treated (for example, high cholesterol, diabetes, high blood pressure, cancer, etc.)
1. _____
2. _____
3. _____
4. _____
5. _____

Past Surgeries/Procedures
Please list every major surgery you have had (for example, tonsils, appendix, gallbladder, prostate, knee replacement, etc.)
1. _____
2. _____
3. _____
4. _____
5. _____

Family History:
Please list the medical problems that run in your family (your parents/your siblings) (for example, diabetes, high blood pressure, heart disease, etc.)

_____

Does anyone in your family have:

Colon cancer:	Yes	No
Hereditary colon cancer syndromes (Lynch, HNPCC):	Yes	No
Other GI cancers (stomach, pancreas, gallbladder):	Yes	No
Liver disease (cirrhosis, cancer)	Yes	No
Inflammatory bowel disease (ulcerative colitis or crohn's colitis):	Yes	No

If you answered Yes to any of the above, please list indicate your relationship to the affected individual (i.e., mother has colon cancer)

_____

_____

Social History:

Occupation _____

Tobacco Use (please circle one) Yes / No / Quit

If yes, how much? _____

If quit, when?_____

Have you ever or do you currently use any illegal drugs? (please circle one) Yes / No

If yes, which one(s)? _____

Alcohol use (please circle one) Yes / No / Quit

If yes, how much? _____

If quit, when?_____

Medications: Please list your medications, including doses and frequency taken

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Patient Signature_____Date_____

Reviewed _____

(FOR OFFICE USE ONLY)